

The following documentation is **REQUIRED** for preauthorization. Incomplete forms will be returned for additional information. For formulary information, please visit the Blue Cross and Blue Shield of Nebraska website at www.nebraskablue.com

Patient Information

Today's Date: _____

Patient Name: _____

Insurance Information

BCBSNE ID Number: _____

Physician/Clinic Information

Prescriber Name: _____	Specialty: _____	
Clinic Name and Address: _____		
Clinic City, State, Zip Code: _____	Phone Number: _____	Secure Fax Number: _____

Preauthorization Information

Requested drug name (please specify brand): _____

Requested dose: _____ Length of treatment: _____

ICD-10 Diagnosis Code: _____

Place of Service:

Physician's office

Home self injection

Home infusion

Outpatient facility

Infusion Center

Other: _____

Has this patient failed other treatments?..... Yes No

If yes, please provide past and present treatments for this indication including drug name, dates of therapy, and response to therapy: _____

Please provide clinical information and documentation for the use of this medication. *If this is a renewal, please include updated labs, progress notes and other pertinent information*: _____

Please fax or mail this form to:
 Blue Cross and Blue Shield of Nebraska
 Pharmacy Department - UM
 1919 Aksarben Drive • PO Box 3248
 Omaha, NE 68180-0001
Toll Free Fax: 877-232-6726
Phone: 877-999-2374

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